Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Midwest Surgery Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-11-2373-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 15, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the allowance for CPT code 23466. The ASC state mandated fee schedule for this code is $3,842.78. We have sent this back for review and they've upheld their initial determination @$2,452.67."

Amount in Dispute: $1,390.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2010	23466	$1,390.11	$1,073.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the guidelines for reimbursement for services provided in ambulatory surgical centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Contract/Legislated Fee Arrangement Exceeded
   - SG – Ambulatory Surgical Center (ASC) Facility Service
   - 193 – Original payment decision maintained

Issues

1. Did the requestor request support calculation of fees?
2. What is the applicable rule in determining appropriate fee(s)?

3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 17, 2011. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

2. The insurance carrier reduced or denied disputed services with reason code 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement," Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.402(f) states in pertinent part, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR (date of service), or its successor. The following minimal modifications apply: …(1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent." Review of the submitted documentation finds: The maximum allowable reimbursement (MAR) will be calculated as follows;

Date of Service	Submitted Code	Amount Billed	Rule 134.402 (f) MAR (Geographically adjusted Medicare ASC reimbursement)
September 15, 2010	23466	$5,687.00	ASC reimbursement divided by 2, multiplied by CBSA city wage index, sum of these two, multiplied by 235% or $1,635.55 ÷ 2 = $817.78 x 0.835 = $682.85 $817.78 + $682.85 = $1,500.63 x 235% = $3,526.48
	TOTAL	$5,687.00	$3,526.48

4. The total maximum allowable reimbursement for the services in dispute if $3,526.48. The carrier previously paid $2,452.67. The remaining balance is $1,073.81. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,073.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,073.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 18, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.